U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7500
(202) 693-7365 (FAX)

Issue date: 19Sep2001

In the Matter of

SHELVIE J. BARTON
(Widow of EMMETT R. BARTON):
Claimant

v.

SEA B MINING CO.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Case No.: 2000-BLA-419

APPEARANCES: Mr. Lawrence L. Moise, Attorney
For the Claimant

Mr. Timothy W. Gresham, Attorney
For the Insurer

BEFORE: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

This matter involves a claim filed by Mrs. Shelvie J. Barton, widow of Mr. Emmett R. Barton, for survivor benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as black lung.

Preliminary Procedural and Evidentiary Discussion

In January 2000, the District Director forwarded Ms. Barton's claim for survivor benefits to the Office of Administrative Law Judges ("OALJ"). In February 2000, Ms. Shannon L. Meade, forwarded to OALJ, on behalf of Mr. Gresham, ten x-ray interpretations (EX 1 to EX 10).[1] Then, pursuant to a Notice of Hearing, dated August 28, 2000, I scheduled a hearing in this case for November 28, 2000 in Greenville, South Carolina (ALJ 1). On November 8, 2000, in anticipation of the hearing, Mr. Gresham sent me a revised exhibit list which listed as EX 11 a medical opinion by Dr. Fino. Mr. Gresham indicated that in accordance with my pre-hearing order, he would present the opinion to me at the hearing. On November 9, 2000, Mr. Moise requested that I make a decision on the record (ALJ 2). Mr. Gresham agreed to a decision on the record provided the claimant was deposed (ALJ 3). The claimant was deposed on December 14, 2000 and the deposition submitted on December 15, 2000. I admit the deposition, as CX 1, into evidence. Likewise, since the decision is to be made on the record, I also admit the employer's exhibits in my possession, EX 1 to EX 10.[2] My decision in this case is based on the documents admitted into evidence (DX 1 to DX 80 , CX 1, and EX 1 to EX 10).[3]

ISSUES

1. Whether Mr. Barton suffered from pneumoconiosis.

2. If Mr. Barton had pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment.

3. If Mr. Barton had coal workers' pneumoconiosis, whether his death was due to pneumoconiosis.

Coal Miner's and Claimant's Backgrounds

Born on May 7, 1936, Mr. Emmett R. Barton married Mrs. Shelvie J. (Childress) Barton on October 2, 1959 (DX 37 and DX 47). Mr. Barton's coal mine employment history started in 1952 with Kiser Coal Co. (DX 28). Over the course of the next 30 years, Mr. Barton worked with several coal

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[1]The following notations appear in this decision to identify specific evidence: DX - Director exhibit; CX - Claimant exhibit; EX - Employer exhibit; and, ALJ - Administrative Law Judge exhibit.

[2]Since I did not conduct a hearing, Mr. Gresham did not present Dr. Fino's report, labeled EX 11, to me.

[3]Because Judge Sullivan has subsequently lifted his injunction concerning application of the new regulations, I need not address the parties' positions on this issue. Absent the injunction, the new regulations are applicable.

companies as a coal loader, cutting machine operator, roof bolter and maintenance foreman (DX 2).[4] Mr. Barton started smoking cigarettes during his twenties at the rate of about half a pack a day. Conflicting medical reports suggest that Mr. Barton may have continued to smoke throughout his life (DX 52 and DX 69). In the last year or two of his life, Mr. Barton struggled with a significant pulmonary impairment which required the near constant use of oxygen (CX 1). Regretfully, Mr. Edward Barton passed away on September 16, 1998 (DX 49 and CX 1).

Procedural Background

A review of procedural histories concerning both Mr. Barton's living miner claim and Mrs. Barton's survivor claim is helpful in understanding the issues in this case.

Mr. Barton's Living Miner Claim

On January 19, 1984 Mr. Barton filed a claim with the United States Department of Labor("DOL") for benefits under the Act. (DX 1). The DOL denied Mr. Barton's claim on September 26, 1984 (DX 11). By letter dated October 5, 1984, Mr. Barton requested a formal hearing with the OALJ (DX 13). A formal hearing was held on August 5, 1987 in Big Stone Gap, Virginia before Administrative Law Judge John S. Patton (DX 28). In November 1987, Judge Patton awarded black lung disability benefits to Mr. Barton (DX 33). Judge Patton stated that Mr. Barton had established 30 years of coal mine employment. While finding that the x-ray evidence on record weighed against a finding of pneumoconiosis, Judge Patton determined that the preponderance of the more probative medical opinion, represented by Mr. Barton's treating physicians, established that Mr. Barton had pneumoconiosis. In addition, based on the short duration of Mr. Barton's smoking history compared to his extensive coal mine employment, Judge Patton concluded that Mr. Baron's significant obstructive respiratory impairment was due to coal dust exposure.

Mrs. Barton's Survivor Claim

Following Mr. Barton's death, Mrs. Barton filed a claim with the DOL for survivor benefits under the Act on November 17, 1998 (DX 44). In March 1999, after a review of the medical record concerning Mr. Barton's death, DOL informed Mrs. Barton that she was not entitled to survivor benefits (DX 61). On April 30, 1999, Mrs. Barton requested a formal hearing before OALJ (DX 62). As noted above, the parties subsequently agreed to a decision on the record.

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[4]Since Mr. Barton last worked as a coal miner in Virginia, the United States Court of Appeals for the Fourth Circuit has jurisdiction over this case. *See Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989)(*en banc*). I also note Mr. Barton passed away in South Carolina which is also in the same jurisdiction.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Elements of Entitlement for a Survivor Claim

Under the Act, and the implementing regulations, 20 C.F.R. §718.205, benefits are provided to eligible survivors of a miner whose death was due to pneumoconiosis. To obtain benefits, a surviving claimant must prove by a preponderance of the evidence several facts. First, the claimant must establish eligibility as a survivor. A surviving spouse may be considered eligible for benefits under the Act if he or she was married to, and living with, the coal miner at the time of his or her death, and has not remarried.[5]

Next, the claimant must prove the coal miner had pneumoconiosis.[6] In the regulation, "pneumoconiosis" is essentially defined as a chronic dust disease arising out of coal mine employment. The definition further includes "any chronic pulmonary disease or pulmonary and respiratory impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[7] Under the Act, this regulatory, or legal, definition of pneumoconiosis is much broader than "medical" pneumoconiosis. *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996).

Third, once a determination has been made that a miner has pneumoconiosis, it must be determined whether the coal miner's pneumoconiosis arose, at least in part, out of coal mine employment.[8] If a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment.[9] Otherwise, the claimant must provide competent evidence to establish the relationship between pneumoconiosis and coal mine employment.[10]

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[5]20 C.F.R. §718.4 indicates that the definitions in 20 C.F.R. §725.101 are applicable. 20 C.F.R. §725.101, in turn, refers to the term "survivor" as used in Subpart B of Part 725. 20 C.F.R. §725.214 then sets out the spousal relationship requirements and 20 C.F.R. §725.215 describes the dependency rules. According to §725.214 (a) the spousal relationship exists if the relationship is a valid marriage under state law. Under §725.215(a), a spouse is deemed dependent if he or she was residing with the miner at the time of his or her death.

[6]For survivor claims filed on or after January 1, 1982, an administrative law judge must make a threshold determination as to the existence of pneumoconiosis under 20 C.F.R. §718.202 (a) prior to determining whether a miner's death was due to pneumoconiosis under 20 C.F.R. §718.205. *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993).

[7]20 C.F.R. §718.201(b).

[8]20 C.F.R. §718.203 (a).

[9]20 C.F.R. §718.203 (b).

[10]20 C.F.R. §718.203 (c).

Finally, the surviving spouse has to demonstrate the coal miner's death was due to pneumoconiosis. For a survivor claim filed on or after January 1, 1982, the Department of Labor regulations provide four means to establish that a coal miner's death was due to pneumoconiosis:[11]

1. Competent medical evidence establishes that the death was caused by pneumoconiosis;

2. Death was caused by complications of pneumoconiosis; or,

3. Pneumoconiosis was a substantially contributing cause or factor leading to the miner's death.

4. The presumption in 20 C.F.R. §718.304 regarding complicated pneumoconiosis applies.[12]

However, a survivor may not receive benefits if the coal miner's death was caused by traumatic injury, or the principal cause of death was a medical condition not related to pneumoconiosis, unless evidence establishes that pneumoconiosis was a substantially contributing cause of death.[13]

Regarding the third method of establishing death due to pneumoconiosis, both the Benefits Review Board ("BRB") and Federal courts of appeal have provided interpretations of what constitutes a "substantially contributing cause or factor."[14] The BRB has stated a coal miner's death will be considered due to pneumoconiosis if the cause of the disease is significantly related to, or significantly aggravated by, pneumoconiosis. *Foreman v. Peabody Coal Co.*, 8 B.L.R. 1-371, 1-374 (1985). The U.S. Court of Appeals for the Third Circuit has further broadened the interpretation by stating that any condition, such as pneumoconiosis, that hastens a coal miner's death is a "substantially contributing cause." *Lukosevicz v. Director, OWCP*, 888 F.2d 1001, 1006 (3d Cir. 1989). In reaching its decision, the court relied on the Department of Labor's comment when publishing Part 718 of the regulation that "pneumoconiosis need not be the 'principal,' sole, primary, or proximate cause of the miner's death in order for the survivor's claim to be compensable." 48 Federal Register Page 24,277 at (n) (1983). In a similar case, the U.S. Court of Appeals for the Fourth Circuit adopted DOL's interpretation that pneumoconiosis substantially contributes to death if it hastens death in any way. *Shuff v. Cedar Coal Co.*, 967 F.2d 977, 979 (4th Cir. 1992), *cert. denied*, 113 S.Ct. 969 (1993). In light of these judicial interpretations, if pneumoconiosis actually hastened a coal miner's death, then it is a substantially contributing cause within the meaning of the

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[11]20 C.F.R. §718.205 (c)(1), (2), and (3).

[12]Under this section, if there is evidence of complicated pneumoconiosis, then there is an irrebuttable presumption that the miner's death was due to pneumoconiosis.

[13]20 C.F.R. §718.205 (c)(4).

[14]20. C.F.R. §718.205 (c)(2).

DOL regulations.

In summary, a survivor's claim filed after January 1, 1982 must meet four primary elements for entitlement. The claimant bears the burden of establishing these elements by a preponderance of the evidence. If the claimant fails to prove any one of the requisite elements, the survivor claim for benefits must be denied. *Gee v. W. G. Moore and Sons*, 9 B.L.R. 1-4 (1986) and *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985). The four elements are: (1) the claimant is an eligible survivor of the deceased miner; (2) the coal miner suffered from pneumoconiosis; (3) the coal miner's pneumoconiosis arose out of coal mine employment; and, (4) the coal miner's death was due to coal workers' pneumoconiosis.

Eligible Survivor

Based on her deposition testimony (CX 1), and the documentation in the record, including both the Barton's marriage license (DX 47) and Mr. Barton's death certificate listing Mrs. Shelvie J. (Childress) Barton as his surviving wife (DX 49), I find Mrs. Shelvie J. Barton is an eligible survivor under the Act.

Issue No. 1 - Presence of Pneumoconiosis

The second entitlement element Mrs. Barton must prove is that Mr. Barton had pneumoconiosis. According to 20 C.F.R. §718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§718.202 (a)(1)); autopsy or biopsy (pathology) report (§718.202 (a)(2)); statutory presumption (§718.202 (a)(3));[15] or medical opinion (§718.202 (a)(4)).

Since there is insufficient evidence of complicated pneumoconiosis in the record, and based on the date Mrs. Barton filed her claim, the statutory presumptions are not applicable. Of the remaining three means to establish pneumoconiosis in a survivor claim, the most probative evidence is biopsy or autopsy reports. Mrs. Barton's claim contains several autopsy and biopsy reports. These evaluations are particularly useful because the radiographic films taken prior to Mr. Barton's demise produced conflicting interpretations concerning the presence of pneumoconiosis.

Autopsy/Pathology Reports

(Note: the following summary, and other remaining portions of this decision, contain detailed information obtained from the autopsy of Mr. Barton, submitted by Mrs. Barton to support her claim.

[15]If any of the following presumptions are applicable, then under 20 C.F.R. §718.202 (a)(3) a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. §718.304 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption that the miner's death was due to pneumoconiosis); 20 C.F.R. §718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. §718.306 (a rebuttable presumption of entitlement when a survivor files a claim prior to June 30, 1982).

While respecting the dignity and privacy of the deceased, some discussion of the detailed observations is necessary because I find the medical information relevant on determining whether Mr. Barton's' death was due to pneumoconiosis.)

Dr. Woodward

On September 17, 1998, Dr. Brett H. Woodward, on behalf of Dr. Rajeev Malik, conducted an autopsy of Mr. Barton with an accompanying microscopic examination of tissue (DX 50 and DX52). Gross examination of the lungs indicated "diffuse anthrocotic[sic] staining," as well as emphysematous change of both lungs. The left lung "main bronchus peribronchial lymph nodes demonstrates a calcified granulomata." Both lungs exhibited neoplasia. Neoplasia in the right lung lead to the obstruction of the right middle lobe bronchus, and a rounded neoplasm was present in the right upper lobe. The right lung weighed 1,600 grams, while the left lung weighed 900 grams. The autopsy also revealed a large pulmonary embolus on the right pulmonary artery. A primary carcinoma was located in the stomach, with metastatic carcinoma observed in both adrenal glands, both kidneys, the omentum and the brain. Dr. Woodward also noted that hypertensive cardiovascular disease and arteriosclerotic cardiovascular disease were present.

Under the microscope, Dr. Woodward observed mucinous adenocarcinoma in tissue from both lungs. Also, in the left lung, "[e]mphysematous pulmonary change is observed with extensive anthracotic pigmentation in the peribronchial and perilymphatic distribution." The anthracotic pigmentation was "extensive" and "suggestive of silica."

As part of his final autopsy diagnosis, Dr. Woodward included "anthrasilicosis of the right and left lungs."

Dr. Crouch

On March 3, 1999, Dr. Erika C. Crouch, a board certified anatomic pathologist, reviewed Mr. Barton's autopsy report, evaluated the autopsy tissue slides, and considered other medical records (DX 59 and DX 60).

In analyzing three slides of lung tissue, Dr. Crouch stated that the involved areas were "most remarkable for multi focal adenocarcinoma consistent with a metastatic gastric cancer." The "uninvolved areas" showed "non-specific reactive changes to the tumor and emphysema." She identified "mild, multi focal coal dust disposition and a few small coal dust macules."

Based on her evaluation, Dr. Crouch diagnosed metastatic carcinoma consistent with a gastric tumor. At the same time Dr. Crouch found insufficient evidence of pneumoconiosis. Although coal dust and coal dust macules were present, Dr. Crouch did not observe any coal dust micro nodules, nodules or areas of massive fibrosis or silicosis. While acknowledging that the sample consisting of only three slides was "suboptimal," Dr. Couch believed the gross findings in the autopsy report also ruled out the presence

of pneumoconiosis.

Dr. Caffrey

On August 21, 1999, Dr. P. Raphael Caffrey, board certified in anatomical and clinical pathology, examined several biopsy slides and reviewed Mr. Barton's medical record and Dr. Woodward's autopsy report (DX 72).

In his microscopic examination of the four lung tissue slides, Dr. Caffrey found diffuse adenocarcinoma, with large areas of edema and necrosis. He noted the presence of a large thromoembolus in one of the slides. On one slide, Dr. Caffrey observed "a moderate amount of anthracotic pigment and two micro nodules with focal calcification of one of them." Another slide displayed "two tiny macules consisting of coal dust with reticulin and focal emphysema." All four slides showed "only a minimal amount of anthracotic pigment." Dr. Caffrey also found evidence of centrilobular emphysema. Based on his review of the autopsy and examination of the lung tissue slides, Dr. Caffrey diagnosed "diffuse metastatic adenocarcinoma . . . ,thromoembolus, centrilobular emphysema, minimal amount of simple coal worker's pneumoconiosis, and moderate amount of anthracotic pigment. . ."

Dr. Tomashefski

On September 10, 1999, Dr. Joseph F. Tomashefski, Jr., board certified in anatomical and clinical pathology, evaluated the tissue slides and reviewed Dr. Woodward's autopsy report, as well as numerous other medical reports (DX 72).

His review of microscopic autopsy slides revealed "extensive involvement of Mr. Barton's lungs by malignant tumor," which exhibited extensive necrosis. He stated that there was a "mild increase in black pigment" within the lungs. Dr. Tomashefski found two 1 millimeter sized macular deposits of black pigment "associated with focal emphysema." He stated that the macules comprised less than five percent of the parenchymal area depicted in the slide. He diagnosed moderate panacinar emphysema. He located a recent thromboembolus in a pulmonary artery, with necrosis consistent with a small pulmonary infarct. Dr. Tomashefski stated that the primary tumor was located in the stomach, with metastatic deposits in the brain, kidney, omentum, peritoneum, hilar lymph nodes and completely replacing an adrenal gland.

According to Dr. Tomashefski, based on the microscopic evidence of two coal macules in his lung, Mr. Barton did have simple pneumoconiosis.

Dr. Buddington

On October 20, 1999, Dr. Richard S. Buddington, board certified in anatomic and clinical

pathology,[16] reviewed Dr. Woodward's autopsy record and the tissue slides (DX 75).

Dr. Buddington stated that he was "in essential agreement" with all of Dr. Woodward's findings. Dr. Buddington found areas of fibrosis with deposition of black anthracotic pigment in the lungs that were surrounded by areas of emphysematous change, with foci measuring up to 1 millimeter. Dr. Buddington opined that these changes are indicative of pneumoconiosis.

Discussion

Of the five generally well qualified doctors who considered the autopsy report and evaluated the lung tissue slides, only Dr. Crouch opined that Mr. Barton did not have pneumoconiosis. The other four physicians present well documented and reasoned opinions that the autopsy and biopsy established that Mr. Barton had simple coal worker's pneumoconiosis. Based on this clear preponderance of expert opinion evidence, I find that Mrs. Barton has established the presence of coal workers' pneumoconiosis in her husband's lungs.

Issue # 2 - Pneumoconiosis Arising Out Of Coal Mine Employment

Although Mrs. Barton has proven, through pathology reports, that her husband had pneumoconiosis, she must also demonstrate that her husband's pneumoconiosis arose out of his coal mine employment. As indicated earlier, under the regulations, if a miner works ten or more years in one or more mines, a presumption exists that his or her pneumoconiosis arose out of coal mine employment. In his award of benefits, Judge Patton found that Mr. Barton had established a history of 30 years of employment in coal mines (DX 33). In addition, Mr. Barton's Social Security Administration earnings history clearly establish continuous coal mine employment from 1960 through 1982 (DX 26). Since Mr. Barton had more than ten years of coal mine employment, and in the absence of sufficient rebuttal evidence, I find his pneumoconiosis arose out of his coal mine employment.

Issue # 3 - Death Due to Pneumoconiosis

Having proved the first three elements of entitlement, Mrs. Barton may receive survivor benefits if the preponderance of the evidence in the record establishes that her husband's death was due to pneumoconiosis. To prove this last element of entitlement, Mrs. Barton must show Mr. Barton had complicated pneumoconiosis (which establishes an irrebuttable presumption of death due to pneumoconiosis), or that her husband's death was caused by pneumoconiosis, or his death was caused by complications of pneumoconiosis, or pneumoconiosis was a substantially contributing cause or factor leading to Mr. Barton's death.

[16]I take judicial notice of Dr. Buddington's board certification, see Attachment No.1.

Complicated Pneumoconiosis

Under the regulations, 20 C.F.R. § 718.304 (b), a massive lesion might qualify as complicated pneumoconiosis. Neither the radiographic record nor, more significantly, the post-mortem medical evaluations in this case establish the presence of complicated pneumoconiosis. Since Mr. Barton did not have complicated pneumoconiosis, Mrs. Barton may not rely on this means of demonstrating that her husband's death was due to pneumoconiosis.

Death Caused By Pneumoconiosis

The record contains insufficient evidence to conclude that pneumoconiosis killed Mr. Barton. The death certificate listed metastatic gastric cancer as the immediate cause of death (DX 49). And, as discussed below, none of the physicians who evaluated the circumstances of Mr. Barton's death believed the coal worker's pneumoconiosis in his lungs, by itself, was severe enough to cause death. In light of the evidentiary insufficiency, I find Mr. Barton's death was not caused by pneumoconiosis.

Death Caused By Complications Of Pneumoconiosis

Mrs. Barton may still receive benefits as a survivor if her husband's death was caused by complications of pneumoconiosis. At this point of the analysis, since the medical experts reached different conclusions concerning the causes of Mr. Barton's death, an extensive review of both the medical record just prior to his death and the evaluations of the individual doctors is important.

Dr. Malik

On August 11, 1998, Dr. Rajeev Malik, board certified in oncology and internal medicine,[17] examined Mr. Barton regarding a suspected carcinoma in his right lung (DX 52). He noted that Mr. Barton's condition had worsened following a carotid endarterectomy in May 1998 (DX 52 contains medical reports concerning this procedure and a cardiac catherization operation during the same time frame). Shortly after the endarterectomy, Mr. Barton had contracted pneumonia, which proved persistent. He had lost 28 pounds in three months. A CT scan revealed metastatic lesions on Mr. Barton's brain. Dr. Malik observed that Mr. Barton had been smoking roughly a pack of cigarettes a day up until 6 months before the visit. Dr. Malik stated that Mr. Barton had "good bilateral breath sounds." The right lung was observed to have "coarse crepitations and rhonchi." Dr. Malik's first clinical impression was a suspicion that Mr. Barton had Pancoast syndrome, secondary to carcinoma of the lung. Dr. Malik also listed pneumoconiosis and COPD (chronic obstructive pulmonary disease) in his diagnosis.

During the August hospitalization, Dr. Malik administered radiation treatment for Mr. Barton's brain

[17] I take judicial notice of Dr. Malik's board certification, see Attachment No.2.

cancer (DX 52). Although Dr. Hand had intended to discharge Mr. Barton on August 18th, Dr. Malik reported that Mr. Barton remained in the hospital for continued radiation treatment of his multiple sites of cancer, in particular the lesions in the brain and a gastric mass (DX 52). Mr. Barton was also treated by other medical specialists including Dr. Winkler and Dr. Snowcroft. By the 14th of September, Mr. Barton was feeling better and was discharged home. Dr. Malik scheduled a follow-up office visit for September 17th. At the time of this discharge, Dr. Malik diagnosed, among multiple ailments, gastric carcinoma to the brain and lung, COPD, sepsis, pneumonia and coronary artery disease.

Two days later, as Dr. Malik described in the death summary (DX 52), Mr. Barton was admitted to the emergency room in the early morning of September 16, 1998 due to dehydration and an increasing shortness of breath.[18] Dr. Malik indicated Mr. Barton had a medical history which included coronary artery disease, severe COPD, black lung disease, and a recent history of metastatic gastric cancer. Over the course of the day, while receiving treatment for severe dehydration, hypotension, hyponatremia and hypochloremia, Mr. Barton experienced increasing "difficulty with oxygenation." Late in the evening, Mr. Barton expired. Dr. Malik's final diagnosis included: severe dehydration with shock; pulmonary embolism; metastatic carcinoma of the brain, lymph nodes and lung; "severe COPD;" and coronary artery disease.

Dr. Hand

Between August 11, 1998 and August 18, 1998, Dr. Stephen H. Hand, one of Mr. Barton's treating physicians, treated Mr. Barton at the Anderson Area Medical Center for persistent headache, dizziness, and nausea (DX 69). Dr. Hand had been treating Mr. Barton for quite a while and reported that, despite assertions of having stopped cigarette smoking, Mr. Barton continued to smell of tobacco and had high carboxyhemoglobin content in blood tests. The hospitalization followed a previous treatment for right lobe pneumonia, which apparently did not resolve itself. Radiographic examinations indicated the presence of cancerous brain lesions, suspicious masses in the adrenal glands and infiltrate superimposed on chronic lung disease. During a bronchoscope examination, Dr. Hand observed a large mass in the right middle lobe. An endoscope examination disclosed an abnormal mass in Mr. Barton's stomach. Pathology reports confirmed the presence of cancer. Chest x-rays showed evidence of COPD and a mass in the right lobe. In the August 18th discharge summary, Dr. Hand diagnosed gastric carcinoma, persistent right lung pneumonia, COPD, coronary artery disease and coal worker's pneumoconiosis (however; as Dr. Malik subsequently reported, Mr. Barton was not released on August 18th; he remained hospitalized until September 14th).

Dr. Kunkel

[18]On September 16, 1998, Dr. Kenneth Nall admitted Mr. Barton into the emergency room of the Anderson Area Medical Center (DX 52). Mr. Barton reported early morning vomiting and severe shortness of breath. As part of his social history, Mr. Barton reported he had been a pack a day cigarette smoker until just about a year prior. His medical history included stomach and brain cancer, black lung disease, emphysema and diabetes.

Shortly after Mr. Barton's re-admission to the hospital on September 16, 1998, Dr. Michael R. Kunkel, board certified in internal medicine,[19] examined Mr. Barton concerning his breathing and nausea difficulties (DX 52). Mr. Barton had also struggled with gastric cancer, "COPD - coal miner's pneumoconiosis," and hypertension. Dr. Kunkel ruled out a cardiac basis for Mr. Barton's chest pain but did not exclude the possibility of a pulmonary embolism. Dr. Kunkel noted that due to his "COPD/pneumoconiosis," Mr. Barton was receiving extensive oxygen therapy and had suffered "post-obstructive right lower lobe infiltrate." He believed Mr. Barton's carcinoma was complicated by "an endobronchial lesion resulting in a post obstructive right middle lobe pneumonia/collapse." Dr. Kunkel took steps to provide comfortable support for Mr. Barton while honoring his desire to avoid heroic measures and life support systems.

Apparently later the same day, Dr. Kunkel signed and certified Mr. Barton's death certificate (DX 49). Annotating that no autopsy had been performed, the physician listed metastatic gastric cancer as the immediate cause of death. Dr. Kunkel then indicated this cancer was a consequence of "coal miner's pneumoconiosis."

Dr. Woodward

Based upon his autopsy examination and microscopic evaluation of the pathology slides, Dr. Woodward opined that the cause of death was "a pulmonary embolus secondary to widely metastatic carcinoma" (DX 50).

Dr. Crouch

According to Dr. Crouch, "occupational coal dust exposure does not contribute to the pathogenesis of gastric carcinoma" (DX 59). As a result, and based on her findings, Dr. Crouch concluded occupational coal dust exposure neither caused any significant impairment nor contributed to, or otherwise hasten, Mr. Barton's death "secondary to pulmonary thromboembolism in the setting of metastatic carcinoma."

Dr. Caffrey

In addition to reviewing the lung pathology slides, Dr. Caffrey reviewed Mr. Barton's medical record from 1982, including the reports from the Anderson Area Medical Center, Dr. Hand's treatment notes, the death summary, death certificate, autopsy report, and Dr. Crouch's consultation report (DX 72). Concerning Mr. Barton's cigarette smoking history, Dr. Caffrey opined that the extent was 50 pack years.[20] Mr. Barton's medical history showed chronic struggle with pulmonary problems, which Dr. Hand diagnosed in 1992 as COPD and pneumoconiosis.

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[19]I take judicial notice of Dr. Kunkel's board certification, see Attachment No. 3.

[20]A pack year represents the consumption of one pack of cigarettes per day for one year.

Based on his extensive review, Dr. Caffrey stated that Mr. Barton had a "very minimal degree of coal workers' pneumoconiosis." The amount of this coal worker's pneumoconiosis would "not cause him respiratory difficulty and did not cause him to quit work in the coal mines." Instead, Mr. Barton stopped mining due to back problems. While the record contained conflicting evidence about the extent of Mr. Barton's smoking, several physician recorded his persistent use, including Dr. Bucci on May 11, 1998 who indicated Mr. Barton was attempting to stop the habit through the use of transdermal nicotine. Consequently, Dr. Caffrey attributes Mr. Barton's chronic bronchitis and emphysema to his cigarette smoking. Dr. Caffrey also opined that Mr. Barton's thirty plus year exposure to coal dust did not cause his gastric carcinoma. While some studies suggest asbestos exposure may be a causative agent for stomach cancer, there is no evidence that Mr. Barton was exposed to asbestos. Likewise, Mr. Barton's multiple other medical problems were unrelated to his coal mine employment. Mr. Barton death was due to "diffuse metastatic adenocarcinoma of the stomach."

Dr. Tomashefski

In addition to evaluating the tissue slides, Dr. Tomashefski reviewed Mr. Barton's medical, social and work histories (DX 72). Dr. Tomashefski stated that the pneumoconiosis in Mr. Barton's lungs was so mild, it would have caused Mr. Barton no respiratory symptoms or impairment. Since the panacinar emphysema was diffuse throughout Mr. Barton's lung tissue, and "not spatially associated with the lesions of coal workers' pneumoconiosis," pneumoconiosis did not cause Mr. Barton's emphysema, heart disease or hypertension. Finally, the pneumoconiosis "was not a cause or a contributing factor in his death." He noted that, while some studies suggest that coal miner's have a slightly greater risk of gastric cancer, the findings are only tentative and there is no evidence that coal dust itself causes gastric cancer. Accordingly, Dr. Tomashefski concluded Mr. Barton's primary gastric adenocarcinoma was not caused by pneumoconiosis or coal dust exposure.

Dr. Buddington

After reviewing Dr. Woodward's autopsy report, Dr. Buddington believed that the pneumoconiosis would have caused "some degree of disability" during Mr. Barton's life (DX 75). However, he also stated that "it should be emphasized that this is in no way the cause of death."

Discussion

Of the many physicians who considered the relationship between coal dust exposure and gastric cancer, only Dr. Kunkel expressed a connection by annotating on the death certificate that the immediate cause of death was metastatic gastric cancer, due to, or a consequence of, coal workers' pneumoconiosis. I give Dr. Kunkel's annotated conclusion little probative weight because it is neither reasoned nor as well documented as the contrary medical opinions. First, while Mr. Barton's medical history informed Dr. Kunkel about Mr. Barton's pneumoconiosis and Dr. Kunkel attended Mr. Barton in his last hours, the physician did not provide any explanation for his assessment that pneumoconiosis caused the stomach

cancer. Dr. Kunkel's medical opinion also has diminished probative value because he rendered it prior to the autopsy and the subsequent pathological findings of minimal amounts of coal workers' pneumoconiosis. Other medical experts relied on the autopsy and biopsy reports to determine that coal workers' pneumoconiosis was not a factor in Mr. Barton's demise. Considering the outcome of the autopsy, the absence of any explanation by Dr. Kunkel for linking coal workers' pneumoconiosis to Mr. Barton's stomach cancer clearly diminishes the value of his death certificate annotation.

Dr. Crouch expressed a contrary view, by stating that coal dust exposure does not cause stomach cancer. However, her conclusion is slightly tainted in Mr. Barton's case because Dr. Crouch did not believe Mr. Barton had coal workers' pneumoconiosis at all.

The other two physicians addressing the complications of pneumoconiosis issue, Dr. Caffrey and Dr. Tomashefski, presented well documented, reasoned and consequently relatively more probative medical opinions indicating no relationship between Mr. Barton's coal workers' pneumoconiosis and cancer. Additionally, both Dr. Caffrey and Dr. Tomashefski noted the absence of scientific evidence to indicate that coal dust exposure causes gastric cancer.

In summary, the clear preponderance of the more probative medical opinion in the record by Dr. Caffrey and Dr. Tomashefski establishes that Mr. Barton's death was not caused by a complication of coal workers' pneumoconiosis.

Pneumoconiosis Was a Substantially Contributing Cause Of, Or Hastened, Death

Even though neither pneumoconiosis, nor its complications caused Mr. Barton's death, Mrs. Barton may still be entitled to survivor benefits if pneumoconiosis was a substantially contributing cause of, or hastened her husband's death. In other words, since the United States Court of Appeals for the Fourth Circuit has jurisdiction over this case, if pneumoconiosis cut short Mr. Barton's life in any manner, Mrs. Barton will prevail with her survivor's claim.

Initially, since Mr. Barton struggled with significant impairment of his lungs and a pulmonary embolism was involved in his death, an argument might be made that his life span was compromised in some manner due to the presence of pneumoconiosis in his lungs. However, absent in this record is any well documented and reasoned medical opinion supporting the proposition that coal workers' pneumoconiosis cut short Mr. Barton's life in some manner. Notably, none of the treating physicians, other than Dr. Kunkel as discussed above, tending to Mr. Barton's care in his last days presented such a conclusion. And, Dr. Kunkel's death certificate assessment linking Mr. Barton's death to pneumoconiosis has little probative valued due to his failure to consider the subsequent autopsy findings.

In contrast, the record does contain documented, reasoned, and probative medical opinion that pneumoconiosis did not contribute or hasten Mr. Barton's death. Two board certified pathologists, Dr.

Caffrey and Dr. Tomashefski, based on extensive reviews of the medical record, including the autopsy report and pathology slides, opined that the extent of coal workers' pneumoconiosis was so minimum that it had no role in, even by hastening, Mr. Barton's death. Their findings that pneumoconiosis had no significant impact on Mr. Barton's death are further supported indirectly by the opinions of Dr. Woodward and Dr. Buddington.

Based on the preponderance of the documented and reasoned medical opinion before me in the record, Mrs. Barton is unable to prove that black lung substantially contributed to, or hastened her husband's passing.

CONCLUSION

The preponderance of the more probative medical evidence establishes that Mrs. Shelvie J. Barton is an eligible survivor and Mr. Emmett R Barton had pneumoconiosis that arose out of coal mine employment. However, the preponderance of the more probative medical opinion demonstrates that Mr. Barton did not died due to pneumoconiosis, or as a consequence of coal worker's pneumoconiosis. The medical record is also insufficient to prove that Mr. Barton's coal workers' pneumoconiosis substantially contributed to, or hastened his death. Accordingly, Mrs. Barton has failed to carry her burden of proof and her claim for survivor benefits under the Act must be denied.

ORDER

The claim of MRS. SHELVIE J. BARTON for survivor benefits under the Act is **DENIED**.

SO ORDERED:

A
RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: September 18, 2001
Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. §725.478 and §725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.

Attachment No. 1:
Who's Certified (www.abms.org)

American Board of Medical Specialties«

Certifications

Important Notice: This site is not approved by the JCAHO and NCQA for commercial use to verify credentials of physician specialists.

Richard S. Buddington, MD
Abingdon, VA

Certified by: The American Board of Pathology

General Certificates:
Anatomic & Clinical Pathology
Subspecialty Certificates:

American Board of Medical Specialties
1007 Church Street, Suite 404 | Evanston, IL 60201-5913
Phone Verification (866) ASK-ABMS
Phone: (847) 491-9091 | Fax: (847) 328-3596

Attachment No. 2:
Who's Certified (www.abms.org)

American Board of Medical Specialties«

Certifications

Important Notice: This site is not approved by the JCAHO and NCQA for commercial use to verify credentials of physician specialists.

Rajeev Malik, MB BS
Anderson, SC

Certified by: The American Board of Internal Medicine

General Certificates:
Internal Medicine
Subspecialty Certificates:
Medical Oncology

American Board of Medical Specialties
1007 Church Street, Suite 404 | Evanston, IL 60201-5913
Phone Verification (866) ASK-ABMS
Phone: (847) 491-9091 | Fax: (847) 328-3596

Attachment No. 3:
Who's Certified (www.abms.org)

American Board of Medical Specialties«

Certifications

Important Notice: This site is not approved by the JCAHO and NCQA for commercial use to verify credentials of physician specialists.

Michael R. Kunkel, MD
Anderson, SC

Certified by: The American Board of Internal Medicine

General Certificates:
Internal Medicine
Subspecialty Certificates:

American Board of Medical Specialties
1007 Church Street, Suite 404 | Evanston, IL 60201-5913
Phone Verification (866) ASK-ABMS
Phone: (847) 491-9091 | Fax: (847) 328-3596